MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address East Harris County Orthopedics Assoc 9343 N. Loop E. #600 Houston TX 77029	MDR Tracking No.: M4-03-6798-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Insurance Co. 2875 Browns Bridge Road Gainesville GA 30504 c/o Box 28	Date of Injury: Employer's Name: Automobile Club of Southern CA Insurance Carrier's No.: 949467034

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
8-29-02	8-29-02	63048	2124.00	0.00

PART III: REQUESTOR'S POSITION SUMMARY

We went through the second opinion process. The insurance carrier failed to respond; therefore, the carrier is responsible for the cost of the surgery.

PART IV: RESPONDENT'S POSITION SUMMARY

Three levels of CPT 63048 were denied, as authorization was not found for these additional levels. The preauthorization was given only for levels T12-L1.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The 1996 Medical Fee Guideline applies to the disputed dates of service. Rule 134.600 (h) (1) requires preauthorization for spinal surgery. Requestor's TWCC-63 includes procedures 63030 and 22630 @ T12-L1. Code 63048 was not preauthorized; therefore, no reimbursement recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Authorized Signature	Typed Name	1-31-05 Date of Decision

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and the TWCC Chief Clerk of Proceedings/Appeals Clerk must receive it within 20 days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____